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ABSTRACT

This pamphlet is designed to assist school personnel in dealing with youth suicide by providing information, and prevention, intervention, and postvention activities. The foreword briefly covers problems facing adolescents that may lead to suicide, and mentions the after effects on the family, school, and community. A message from New York Lieutenant Governor Del Bello is included, in which he urges the formation of a federal commission to investigate causes and prevention of youth suicide. Estimates of the incidence of suicide are given, as well as specific reasons for the increase in suicides. Characteristics of the at-risk population are listed, and prevention, intervention, and postvention activities are briefly discussed. A quick reference guide and summary for identification and action includes a Risk Assessment Checklist, counseling guidelines, and a list of important facts and fables about suicide. Eleven references are included. Appendices include the names and addresses of Children and Youth Services operated by New York State Psychiatric Centers, New York State Division for Youth Field Representatives, New York State Mental Hygiene Commissions and County Mental Health Directors, New York State Poison Control Centers, and New York City Suicide Prevention Hotline numbers. (BH)

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Suicide Among School Age Youth

December, 1984

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THE STATE EDUCATION DEPARTMENT
Office of General Education
Albany, New York 12234

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FOREWORD

Suicide is shocking. It is even more disturbing when it happens to a youngster, someone with the prospect of a long, happy and productive life. We sometimes think of the young as having few cares or problems, and certainly no reason to commit suicide. Yet, we know early adolescence is a time of physical, psychological, emotional, and social changes. Puberty arrives, often unannounced and usually not understood. Peer approval and acceptance become all important. There is a resistance to authority but a need for discipline. Adolescence is a period of conflict and paradox for youngsters passing from childhood to adulthood.

Remmers and Radler (1957) describe well the adolescent predicament:

> "A boy or girl whose energies are already sapped by the sheer prowess of physical growth, caught up in a whirl of school work and social activities in and out of school, confronted by decisions that will affect his entire life, confused by the shifting attitudes of parents, teachers, and society in general, all of whom doubt him and his behavior — and bewildered by the complex and rapidly changing civilization into which he must soon fit, assuming all the responsibilities of maturity."

Harvey (1974) tells us the individual adolescent is a tremendously complex entity, about whom we can know relatively little. Yet, we can characterize him or her quite thoroughly without much difficulty. By nature he or she is inconsistent and unpredictable, acting like an adult one day and a child the next. Adolescence is a time of change. He may be a boy and a man, she a girl and a woman. Each rebels, wanting discipline while at the same time struggling for freedom.

Too often, adults forget that adolescents are people — individuals with unique failings and problems. The tragic results of this oversight are evident everywhere. It is apparent in the alarming rate of school dropouts. It is obvious in the long failure lists in schools. It is conclusive in the high incidence of rejection in the armed services for physical, educational and psychological reasons. It is mirrored in the ever-rising rate of juvenile delinquency and adult crime. It is vividly etched in our con-

sciousness as we read about teenagers' ultimate solution to an uncertain time — **Suicide.**

Although New York has a suicide rate lower than the national average for teenagers, even a single suicide causes grave concern and turmoil in the home, school, and community and requires immediate action on the part of school personnel. This action must be based upon advance planning and preparation. Suicide, after all, does not allow anyone a second chance.

School districts in which a student suicide has occurred report that the event has a devastating impact on the school and the community, as well as on the family of the student. By example, the teen suicide becomes evidence of futility and desperation for other adolescents. Teachers, counselors, administrators, parents, and fellow students are stunned, often overwhelmed with feelings of guilt and helplessness. Many often blame each other — and themselves — feeling someone should have been more alert and sensitive. Concern is usually expressed that there must be other vulnerable students, and questions are raised about what can be done to help them. Schools may bear the brunt of community criticism for not somehow preventing the suicide.

In recognition of the tragedy of youth suicide and in an attempt to move aggressively on this problem as a State, Governor Cuomo has appointed a State Council on Youth Suicide Prevention. The Council, chaired by Lieutenant Governor Alfred B. Del Bello, is made up of: State Commissioners of Mental Health, Education, Health, the Director of the Division for Youth, key legislators, parents and other professionals. It is the Council's task to develop a coordinated and comprehensive approach to reduce the tragic incidence of youth suicide in New York State.

The attached paper is a step toward assisting school personnel in dealing with prevention, intervention and postvention activities regarding youth suicide. It emphasizes the impact of

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H. H. Remmers and D. H. Radler. The American Teenager. New York: Bobbs-Merrill Company, Inc., 1957

P. J. Harvey. "Teacher Attitudes: Subject Matter and Human Beings" in Middle School in the Making. Washington, D.C.: ASCD, 1974

youth suicide on schools and communities. The paper was prepared by members of the Bureau of Pupil Services with the assistance of agencies and organizations including the State Office of Mental Health, professionals with experience in suicide prevention and treatment, and officals from school districts which have suffered a suicide in their student population or have developed programs to prevent such tragedies. Should you have any questions, please contact the Bureau of Pupil Services, State Education Department, Albany, New York 12234; (518) 474-3869.

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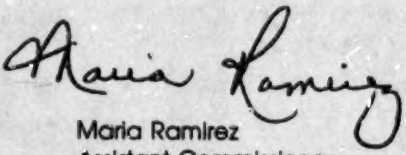
David Tooley, Special Assistant, Office of the Lieutenant Governor



Maria Ramirez
Assistant Commissioner
Office of General Education

A MESSAGE FROM LIEUTENANT GOVERNOR ALFRED B. DEL BELLO

Needed: A U.S. Commission on Teen-Age Suicide
New York Times – September 12, 1984

When the bright promise of a teen-ager's life is sacrificed by suicide, we are haunted by an unequaled sense of loss, tragedy, and anger. There is no greater pain that a parent, family and community can suffer.

When a rash of teen-age suicides struck the Westchester area this year, many viewed them as isolated, local tragedies. But suicide has overtaken homicide as the second largest killer of youth between 15 and 24 years of age in our nation. Growing at triple the rate of the 1950's, suicide now claims the lives of more young men and women than cancer – and we don't know why. We do not understand the forces and changes in our society that underlie this terrible phenomenon, and we have done little as a nation to come to grips with our No. 1 preventable cause of death.

Some experts say one in every 10 students is "at risk" – meaning they have not only thought about killing themselves but have planned it. For every suicide, 50 to 100 other youths are said to make an attempt on their own lives. But we are only guessing at the full dimensions of the problem. Many suicides are not reported as such, to spare pain and stigma to loved ones. Many are masked as accidents and homicides, with single car auto deaths now under study as a form of unreported suicide. According to some authorities, the real figure may be four times higher than the 6,000 youth suicides estimated last year. We need to find out.

We know even less about why these thousands of youths choose to die. Many people blame drug and alcohol abuse.

Others see such abuse and suicide as related symptoms of much more basic problems in our social fabric. Family dynamics, shifting value systems, increased personal freedom and responsibility, the complex demands of our society on adolescents — all are said to contribute to suicidal behavior. Still others look to biochemical and even genetic bases of depression and suicide.

We must ask: Are our children so ignorant of death that they don't appreciate its meaning and finality? Have we failed to provide teen-agers with the tools needed to cope in today's world? Are traditional therapeutic approaches for troubled youth failing? What pain, guilt, fear or desperation is driving these confused young people to inflict such severe punishment on themselves? What are they escaping from? We must be prepared to look at some of the ugliest sides of our society if we are to unearth the root causes of youth suicide.

Parents who have lost a child to suicide express frustration in trying to warn others that suicide knows no geographic, economic or social barriers. It is not limited to "problem kids" and could strike your family tomorrow.

Yet we offer our kids little advice about what they should do when a friend talks of suicide. We offer little guidance to parents, fostering the attitude that "it won't happen to us" in our homes and schools. We go on speculating about the causes and solutions, rather than committing the resources needed for research and prevention programs.

Some important steps are under way, but far more needs to be done. Valuable research into pieces of the youth suicide puzzle is being conducted through the National Institute of Mental Health and the Center for Disease Control. Statewide efforts to put prevention programs into schools have been initiated in California and New York. A model program being developed in New York will give teachers, counselors, administrators, parents, and students basic "suicide awareness" information: how to recognize if a friend is "at risk," what to do and what not to do. But no comprehensive research base exists, and we are only inching forward toward more comprehensive answers. Without Federal leadership, many other states will be forced to slowly reinvent the wheel.

A National Committee on Youth Suicide Prevention — a volunteer network of concerned parents, professionals and

government officials — has formed to begin sharing information, sponsor training conferences, and spur state governments into taking on the problem locally. But the problem cries out for a Federal response coordinated and mandated by Congress. An exhaustive research and planning effort — in the form of a Federal commission — is needed to launch and consolidate efforts to investigate the causes of youth suicide, concentrating on the practical task of preventing such deaths.

Such a Federal effort could survey the world for tested intervention methods — telling us what can be done in our schools, and how communities can implement low-cost programs to help save lives. This fall, the national committee will ask each state legislature to petition Congress to create such a Federal commission in its next session.

The only age group in America whose mortality rate is consistently rising is our 15-to 24-year olds, and suicide is the fastest growing cause of death among these young people. So far, our response has been largely cosmetic and feeble. Why? Are we so unable to overcome the stigma attached to suicide? Is the search for answers so threatening?

Those who believe suicide is unstoppable are wrong — tragically wrong. We must look the problem straight in the eye and respond on behalf of those thousands of young people who will otherwise choose death over life. The more rapidly we act, the more lives we will save.

SUICIDE AMONG SCHOOL AGE YOUTH

The suicide of a student will have an extremely disturbing effect on the school and the local community. Unfortunately, there has been a significant increase in the number of adolescents who choose suicide as a way to resolve their problems. This paper is intended to alert school personnel to the implications of suicide by a student, to help the school and the community cope with the aftermath of such a tragic event should it occur, to recommend ways of identifying children and adolescents at risk of attempting suicide, and to suggest ways to prevent such occurrences.

Estimate of Incidence

Statistics from the National Center for Health Statistics (U.S. Department of Health and Human Services) indicate that, nationwide, approximately 5,000 teenagers commit suicide each year. Suicide is the second leading cause of death among adolescents in the United States. There were three times as many adolescent suicides in 1980 as compared with 1955. Half a million suicide attempts are reported each year, more by females than males. More males succeed in taking their own lives, however, by four to one.

New York State Health Department (Bureau of Health Statistics) data show that the percentage of New York State youth who take their own lives is lower than the national average. (Ninety-four deaths were reported for the 10-19 age group in 1983.) However, suicide is still the third leading cause of adolescent deaths in New York State.

Furthermore, many experts believe that a significant number of teen-age auto accidents are, in actuality, disguised suicides. All too frequently it is found that a teenaged accident victim has abused alcohol or drugs and has lost control of the car. These accidents increase in number on weekends, occur most often in the spring of the year, many times just before high school graduation.

Why the Increase

There are no clear answers as to why a teen would commit, or attempt to commit, suicide, since there is little research on the subject. What is extremely important, however, is that teenagers who attempt or commit suicide may not simply be struggling with teenage problems unsuccessfully, but may be suffering from significant mental illness. There are several kinds of problems facing adolescents today which may be contributing factors to suicide, although not all experts agree on their relative importance and few experts would suggest that all adolescents react the same way to these factors.

- Stress from external sources.

  Adolescents live under stress from various sources such as school grades, examinations, rules, college requirements and admission deadlines, the threat of nuclear annihilation, poor nutrition and health care, atmospheric pollution, and lack of a healthy home or community situation.

- Fear of change and their ability to handle it.

  Teenagers constantly hear of violence and catastrophe in news broadcasts and see upsetting topics depicted in movies and on television. At the same time, they are not able to put these events into a meaningful perspective. They are not being prepared to deal with adult topics or adult roles in society.

- Problems dealing with the physical and psychological changes in their lives.

  In addition to external pressures, teenagers encounter normal difficulties in growing up, in dating, in finding out who they are, in doubting their abilities, in coping with their feelings, in dealing with such important events as pregnancy and abortion — in many cases, they go through much of this period fearful and confused. Some are simply unable to deal with the pressures which confront them. They are not equipped with adequate coping skills.

- Loss of the traditional support system in today's society.

Some experts attribute the causes of suicide among youth to the breakdown of the family unit through divorce, separation, or both parents working. Often, factors such as geographic mobility deprive young people of the traditional support systems associated with home, family, and community. One of the most important aspects of the support system which seems to be missing for many is the strong adult role model who sets limits and expectations which are both realistic and important to the stability of adolescent behavior. The use of alcohol and illicit and dangerous drugs also may serve as a contributing cause of suicide.

- Unrealistically high expectations.

  For the academically capable student, parents, school staff, and the student himself or herself may have unrealistically high expectations. These expectations can include too much responsibility and too many privileges for the adolescent already struggling with so many changes. The adolescent may have little understanding of how to cope with such pressure. They cannot deal with defeat. With no one to talk to and obtain help from, the teen may decide his or her own course of action based on hopelessness and despair. Unfortunately, suicide has increasingly become an acceptable alternative to adolescents who feel they are without apparent hope or solutions.

- Unclear perception of death.

  For today's generation of adolescents who depend so much on television and movies for entertainment, it is very possible that teenagers do not truly understand that death is final and that it can happen to them even though their heroes escape every week on television.

It cannot be emphasized strongly enough that children and adolescents, even those who appear physically mature, need support from those around them, particularly in helping them to develop positive self images and perceptions of their ability to handle problems. All too frequently, school staff report that they

were not aware of any problems facing a youth who has just attempted or committed suicide. Even the youngster's own parents frequently report they were not aware of any problem. The support system simply has too many cracks in it to catch some of these children-at-risk. Young people need constant support, and their parents are not always aware of these needs. Even adults who deal with young people in schools and in other youth-oriented settings do not always recognize these needs. **For many youngsters, there appears to be no support available anywhere, at home, at school, or in the community.**

The At Risk Population

Who are the young people who need help? How are they recognized? How can the schools assist them? How can schools help prevent a suicide from taking place?

Experts on suicide believe **almost all** who attempt suicide offer clues to their intentions prior to attempting suicide and most show some signs of depression, but that there will always be a percentage of suicides that are totally unpredictable and impulsive. These signs will be recognized only if someone is aware, alert and interested in the students themselves. **Personal, concerned, human contact between a competent professional staff member and the person at risk is still the best way of preventing suicide where prevention is possible.**

According to suicidologists, students at risk of suicide may display one or more of the following characteristics, but there may be suicides where none of these is found.

A student at risk of suicide often:

- has previously attempted suicide.
- has made a suicidal gesture (cut off hair, self-inflicted cigarette burns, self-abusive behaviors);
- is socially isolated (no friends or only one friend);
- has a record of school failure or truancy (may have dropped out of school already);
- comes from a broken home, has experienced a broken relationship at home, or has a family crisis at the time of the suicide;

- is highly perfectionistic, self-critical, and has low self-esteem;
- has spoken of suicide, either his or her own or others;
- has a close friend or relative who was a (recent) suicide;
- has experienced alcoholism or drug abuse in family or self;
- is not living at home;
- is a victim of domestic violence or child abuse at home;
- is preoccupied with death or dying;
- has had a significant loss or anniversary of a significant loss.
- displays sudden disruptive or violent behavior in dealing with others;
- has deep depression and feelings of worthlessness;
- is more withdrawn, uncommunicative, and isolated from others than usual;

In addition, the student may have:

- told others of definite plans to commit suicide;
- made arrangements to give away possessions;
- undergone marked changes in behavior ("class clown", dare-devil behaviors, suddenly hyperactive), at school or at home, involving eating, sleeping, studying, or grooming habits, or in using drugs or alcohol;
- a background of hyperactivity or neurological impairment.

Taking Action

One major purpose of this paper is to alert school personnel to what happens after the suicide of a student and to suggest some ways of successfully dealing with the feelings of frustration and helplessness which accompany it. These suggestions comprise the third part of the three-part program of preventing adolescent suicides, treating students at risk of committing suicide, and handling the aftermath of a suicide. Suicide experts use the terms prevention, intervention, and postvention to describe each of the parts.

Suicide prevention, intervention, and postvention are not the responsibility of the school alone, however. The com-

munity at large, including the families who live in the community, the community agencies, and the school, must all be involved. It is necessary to mobilize all the resources of the school and the community to sensitize staff, students, and parents about suicide, and to improve the mental health climate in the school and community.

PREVENTION

The prevention aspect begins by educating students, staff members, and people in the community to the threat of suicide and to the need for and means of prevention. Professionals from outside agencies should be contacted when any kind of program is begun so that the network may be used immediately.

School personnel can introduce discussion about suicide into many high school subjects such as health, social studies, literature, psychology, sociology, home economics, family life education, continuing education, and through other activities in the school, such as parent-teacher meetings, study circles, staff development workshops, and superintendents' day programs. The school may also want to consider establishing support groups to help youth deal with many of the more common problems they may face, including divorce, death, or other recent traumatic events in their lives. Perhaps this can be done as simply as a "drop-in center" which is staffed by a professional or a peer counselor who will listen when needed.

A member of the pupil services staff or an outside consultant in suicidology can provide leadership in these efforts. Expert assistance may be available through local mental health clinics or boards, state and private hospitals and agencies, colleges and universities, and private practitioners in mental health and human service areas. Often, such experts prefer a workshop format with small groups of students.

It is helpful to have discussions with representatives from the media during this stage of the program to discuss ways the media can influence adolescents during a crisis. Suicide should never be front page news and must be strictly factual. Too much press can encourage imitation.

The appendices contain the names, addresses and telephone numbers for several community agencies that can assist schools in dealing with students at risk of suicide.

INTERVENTION

The second step is the intervention phase. This is begun by alerting local helping professionals that the school is planning to institute a suicide education and prevention program and that they may be called upon to provide immediate treatment services to an individual at risk of suicide.

It is important to identify those psychiatrists, psychologists, or social workers who are skilled in suicide treatment **before** a need arises. Mental health personnel should be informed of the school's efforts and the possibility of demands upon their services, and should be asked to participate in local programs. Peer counselors can be trained to help their classmates and to spot one in trouble.

The word LOCAL must be emphasized. Ready access locally to treatment is absolutely necessary.

POSTVENTION

Coping with the aftermath of a suicide, the third step, is as critical as the other phases, yet few people are experienced and skilled in dealing with the effects of a suicide. Should a suicide occur, there must be an immediate local response to help the school through the aftermath. Local persons who have experience in dealing with suicide and its effects previously are a most valuable resource. School district staff members may be capable in this area, but they may also be so personally involved in the occurrence that they, too, will need assistance in recovering from the event.

It may be necessary, however, to go beyond the immediate locale to find someone skilled in helping an entire school population and surrounding community deal with the grief and shock of a student suicide. Parents, the community, and clergy should be aware of the "domino effect" of teen suicide. ("If my best friend did it, I can, too.")

If a suicide should occur, the entire school and community will find it difficult to deal with anything else for several days. Every effort should be made, however, to carry on with "business as usual." The following steps should help the school and the community to deal with the immediate impact of a suicide.

1. As soon as possible, the faculty should be brought together to plan for dealing with the adolescent's suicide in individual classroom groupings. It is important to avoid any factors likely to promote imitation. The best persons to conduct such a meeting are consultants already identified as resource personnel. These professionals will help everyone realize that no one can be accused of responsibility in the death of another and that even highly skilled professionals **cannot always** predict, or prevent, suicide. Also, known circumstances can be shared and disturbing rumors stopped before they can get started.

2. Condolences should be expressed and help should be offered the family and close friends of the victim by the pupil services unit on behalf of the district. Be careful not to interfere with the grief process of the family. Timing of contacts is essential. A list of resources in the local area should be maintained by school personnel for this purpose.

3. One school person should be designated spokesperson to answer the questions of press and community. Enough information should be provided so that the living do not identify themselves with the problems of the dead. Avoid generalizations. Let the police handle most of the questions.

4. The spokesperson and staff should also be aware of the characteristic distortions parents will introduce: scapegoating the teachers and peers, minimizing intrafamilial problems, and overstating the unrecognizability of prior signs.

5. Adult study circles and small discussion groups should be started by the pupil services unit as soon as possible after the occurrence. Meetings such as these will help dispel the feelings of helplessness and frustration which are pervasive for the first few days. They also provide a vehicle for further action.

6. Students who feel they need help should have the opportunity to meet in small groups with appropriate professionals schooled to guide them in releasing their

feelings, developing understandings about suicide and discussing strategies and courses of action for the future. All feelings should be accepted, without challenge, whether positive or negative.

7. The pupil services unit (guidance, school psychology and school social work, and health) should be prepared immediately to accept an increased number of formal referrals and to work actively in other ways with pupils, staff and parents.

8. Above all, however, business should be conducted as usual insofar as is possible. The upsetting event should not be allowed to interfere with normal activity any more than absolutely necessary.

Other Considerations

Trained professionals are able to recognize significant signs of students at risk of suicide. Teachers, counselors, and parents can learn to recognize them. The school should have a referral system which specifies what should be done when someone recognizes signs of potential suicide, and to whom (in the school building and district) such a suspicion should be reported. All staff need to be aware of the system and its importance.

Students will also begin to recognize signs of potential suicide in some of their friends as a result of the education portion of the prevention program. They, too, must know how to obtain help for their friends and themselves should it be necessary.

Students need to talk, to ventilate, about the problems that trouble them, to learn how to solve problems, to get the opinions of others, and to share experiences with others having the same difficulties. This is especially important should a suicide have occurred. A drop-in center, staffed by a pupil services specialist or teacher trained in suicide prevention, might be one approach. Schools should have trained persons, someone to whom young people can relate, who go to the places where students congregate in the building, to help and to listen. Several experts have recommended peer counseling programs as useful, as well.

It is important to realize and make known that the signs of potential suicide are almost always evident, but they must be recognized. Pay attention to the students for the signs. The problem is that there is no sure way of predicting who will attempt suicide or complete a suicide attempt. There is also no way to determine when someone who threatens an attempt or fails to complete the attempt is crying for help or really trying to die. Even though someone may correctly predict that there is a risk, he or she may be powerless to stop the suicide attempt, just as the person who attempts suicide may be powerless to find another way to solve his or her problems.

It is also important to remember that while 5-10% of adolescents, 15-19 years of age, may exhibit some of the signs of being at risk, only about one in thirteen thousand teenagers will actually commit suicide each year and not all of those will display at risk behavior. This does not mean that increased efforts within the family, school, and community to "tune in" to adolescent behavior are futile. Even where students exhibit at risk behavior and are not contemplating suicide, they do need extra support and encouragement from all parts of society and can benefit from any efforts made to help them.

The hope is that well-planned efforts by educators, in cooperation with mental health professionals and the community-at-large, will make a significant contribution to the reduction of teen suicides in New York State and better mental health for all teenagers.

QUICK REFERENCE GUIDE AND SUMMARY FOR IDENTIFICATION AND ACTION

RISK ASSESSMENT CHECKLIST

- Has the person recently withdrawn from therapeutic help?
- Has the person been abusing drugs or alcohol recently?
- Is there a history of suicide in the person's family?
- Is the person exhibiting marked hostility to those around him or her?
- Has the person's life become disorganized recently?
- Does the person drop in and out of school?
- Has the person become unusually depressed or anxious recently?
- Has a friend committed suicide recently?
- Has a relative committed suicide recently?
- Has the person threatened suicide, or spoken about it with friends or teachers?
- Is the person preoccupied with themes of death or dying?
- Has the person made previous suicide attempts?
- Does the person have trouble holding onto friends?
- Does the person have a "plan" for suicide, and has the person made preliminary arrangements?
- Has the person made "final arrangements" (given away possessions, said "Goodbye")?

IF YOU BELIEVE SOMEONE MAY BE THINKING OF SUICIDE, GET HELP FOR THAT PERSON BY IMMEDIATELY CONTACTING PEOPLE DESIGNATED IN THE DISTRICT PLAN ON SUICIDE PREVENTION. DO NOT WAIT!

COUNSELING GUIDELINES

If someone wants to talk:

- Accept what is said, and treat it seriously.
- Do not give advice.
- Do not say everything will be all right.
- Do not back off or try to delay dealing with the person.
- Help the person explore feelings. Do not add to the person's guilt. (e.g., "Think how your parents, friends, etc. would feel!")
- Ask if the person is considering suicide if such information is not forthcoming. It is OK to talk about suicide, and it will not give the person an idea he or she has not thought of.
- Try to focus the problem.
- Help determine what needs to be done or changed.
- Help identify the resources needed to improve things.
- Help the person recall how he or she used to cope.
- Get the person to agree to do something constructive to change things.
- Arrange with the person to be back in contact within a few hours. Offer yourself as a caring and concerned listener until professional assistance has been obtained.
- Trust your suspicions that the person may be self-destructive.
- Communicate your concern for the well-being of the person. Be an active listener and show your support.
- Talk openly and freely and ask direct questions about the person's intentions. Try to determine whether the person has a plan for suicide — the more detailed the plan, the greater the risk.
- Encourage the person to seek help from a school counselor, minister, or someone who is trained to help solve emotional problems. If the person resists, you may have to get the necessary help for him or her.
- Call the police if the situation is immediately life-threatening.

- Do not leave the person alone if you believe the risk of suicide is immediate.
- Do not swear secrecy to the suicidal person. You may lose a friendship, but you may save a life.
- Do not debate whether suicide is right or wrong. This may make the person feel more guilty and worthless.

FACTS AND FABLES

- **Fable:** People who talk about suicide don't commit suicide.
  Fact: Of any 10 persons who kill themselves, eight have given definite warnings of their suicidal intentions.
- **Fable:** Suicide happens without warning.
  Fact: Studies reveal that the suicidal person gives many clues and warnings regarding his or her suicidal intentions.
- **Fable:** Suicidal people are fully intent on dying.
  Fact: Most suicidal people are undecided about living or dying and they "gamble with death," leaving it to others to save them. Almost no one commits suicide without letting others know how he or she is feeling.
- **Fable:** Once a person is suicidal, he or she is suicidal forever.
  Fact: Individuals who wish to kill themselves are suicidal only for a limited period of time.
- **Fable:** Improvement after a suicidal crisis means that the risk is over.
  Fact: Most suicides occur within about three months of the beginning of "improvement," when the individual has the energy to put morbid thoughts and feelings into effect.
- **Fable:** Suicide strikes much more often among the rich and-or the poor.
  Fact: Suicide is neither the rich man's disease nor the poor man's curse. Suicide is represented proportionately in all levels of society.
- **Fable:** All suicidal individuals are mentally ill, and suicide always is the act of a psychotic person.
  Fact: Studies of hundreds of genuine suicide notes indicate that although the suicidal person is extremely unhappy, he or she is not necessarily mentally ill.

REFERENCES

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suicide, including causes of suicidal behavior, the recognition of and response to its symptoms, and methods of prevention.)

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10. Joan, Polly. **The LIVING Alternative Handbook**, Ithaca, NY: Suicide Prevention & Crisis Service of Tompkins County, Inc. 103 pages. Bibliography. (A program model (curriculum) for guiding adolescents in ways to understand and cope with depression and/or suicidal feelings.)

11. Frederick, Calvin J. "Adolescent Suicide." **Advocacy for Children**, U.S. Department of Health, Education, and Welfare, Office of Human Development Services, Children's Bureau, Washington, D.C. 1978. 10 pages. Bibliography. (Suggests ways of increasing awareness of adolescent suicide and ways of intervening to prevent it; presents profiles of suicides among young people; outlines clues to suicidal behavior; offers "first aid" advice to prevent a suicide.)

APPENDICES

The appendices that follow contain the names, addresses, and telephone numbers for the following community agencies that can assist local schools in dealing with the problems of suicide among school age youth:

- Children and Youth Services in New York State
- Children's Psychiatric Centers in New York State
- New York State Division for Youth Field Representatives Office Location
- New York State Mental Hygiene Commissioners County Mental Health Directors

CHILDREN'S AND ADOLESCENT SERVICES OPERATED BY STATE PSYCHIATRIC CENTERS

Binghamton Psychiatric Center
Louis Dozoretz, M.D.
Executive Director
William Yelverton, Unit Chief
Children and Youth Services
425 Robinson Street
Binghamton, NY 13901

(607) 773-4184

Capital District Psychiatric Center
Jesse Nixon, Jr., Ph.D.
Executive Director
James McIntyre, M.D., Chief of
Service, Children and Youth Services
75 New Scotland Avenue
Albany, NY 12208

(518) 445-6911

Hutchings Psychiatric Center
Hal Margosian
Executive Director
Joyce Cary, Unit Chief
Children and Youth Services
P.O. Box 27, University Station
Syracuse, NY 13210

(315) 473-6688

Manhattan Children's Psychiatric Center
Cynthia Barnes, M.D.
Executive Director
600 East 125 Street
New York, NY 10035

(212) 369-0500

Bronx Children's Psychiatric Center
E. Richard Feinberg, M.D.
Executive Director
1000 Waters Place
Bronx, NY 10461

(212) 892-4477

Elmira Psychiatric Center
Bert W. Pyle, Jr.
Executive Director
Don Lynn, M.D., Unit Chief
P.O. Box 1011
Elmira, NY 14902

(607) 737-4787

Kingsboro Psychiatric Center
Louis Smith
Executive Director
Helen Coronges
Children and Youth Services
681 Clarkson Avenue
Brooklyn, NY 11203

(212) 735-1376

Marcy Psychiatric Center
Richard M. Health
Executive Director
Dr. Josefa Tuason, Unit Chief
Children and Youth Services
P.O. Box 100
Marcy, NY 13403

(315) 736-3301, Extension 366

Queens Children's Psychiatric Center
Gloria Fareira, M.D.
Executive Director
74-03 Commonwealth Boulevard
Bellerose, NY 11426

(212) 464-2900

Rockland Children's Psychiatric Center
Satwant Ahluwahlia, M.D.
Executive Director
Convent Road
Orangeburg, NY 10962

(914) 359-7400

South Beach Psychiatric Center
Lucy Rea-Sarkis, M.D.
Executive Director
Gideon Trokan, Unit Chief
Children and Youth Services
777 Seaview Avenue
Staten Island, NY 10350

(212) 667-2309

Western New York Children's Psychiatric Center
Cecile Davis, CSW, MSW
Executive Director
1010 East and West Road
West Seneca, NY 14224

(716) 674-9730

Rochester Psychiatric Center
Martin Von Holden, D.P.A., M.A.
Executive Director
Thomas Vallie, Unit Chief
Children and Youth Services
1600 South Avenue
Rochester, NY 14620

(716) 473-3230, Extension 1296

Sagamore Children's Psychiatric Center
Robert Schweitzer, Ed.D.
Executive Director
Box 755
Melville, NY 11746

(516) 673-7400

St. Lawrence Psychiatric Center
Lee Hanes, M.D.
Executive Director
Donald Sawyer, Unit Chief
Children and Youth Services
Station A
Ogdensburg, NY 13669

(315) 393-3000, Extension 3338

NEW YORK STATE DIVISION FOR YOUTH
FIELD REPRESENTATIVES OFFICE LOCATION

FIELD REP.	OFFICE LOCATION
JOSEPH BAIANO	Franklin County Court House Malone, NY 12953 (518) 483-4040
LESTER BROWN	State Office Bldg. 164 Hawley St. Binghamton, NY 13901 (607) 773-7778
DOMINIC CASTORE	Adam Clayton Powell, Jr. State Office Bldg., 14th Fl. 163 W. 125th St. New York, NY 10027 (212) 678-2359
ROBERT DAGOSTINO	1653 Central Ave. Albany, NY 12205 (518) 457-3147
VALERIE FIELDS	State Office Bldg. Veterans Highway Hauppauge, NY 11787 (516) 360-6289
ARTHUR FREIJE	P.O. Box 421 214 E. Church St. Elmira, NY 14902 (607) 733-7186
MARIA GALARZA	1019 Park St., Room 208 Peekskill, NY 10566 (914) 736-0950

CHRIS GARMON	1080 Ellicott Square Bldg. 295 Main St. Buffalo, NY 14203 (716) 847-5075
JOSEPH GIOVINO	1080 Ellicott Square Bldg. 295 Main St. Buffalo, NY 14203 (716) 847-5075
RICHARD LASKOWSKI	1080 Ellicott Square Bldg. 295 Main St. Buffalo, NY 14203 (716) 847-5075
MARTIN LEWIS	State Office Bldg. Veterans Highway Hauppauge, NY 11787 (516) 360-6289
MARILYN MASICK	A.C.P. State Office Bldg. 14th Fl., 163 W. 125th St. New York, NY 10027 (212) 678-2357
RICHARD McKNIGHT	State Office Bldg. 333 E. Washington St. Syracuse, NY 13202 (315) 428-4229
LARRY MILLER	A.C.P. State Office Bldg. 14th Fl., 163 W. 125th St. New York, NY 10027 (212) 678-2362

CHARSIE MORGAN	A.C.P. State Office Bldg. 14th Fl., 163 W. 125th St. New York, NY 10027 (212) 678-2360
DENISE MUELLER	State Office Bldg. 207 Genesee St. Utica, NY 13501 (315) 793-2583
JULIA RIVERA	A.C.P. State Office Bldg. 14th Fl., 163 W. 125th St. New York, NY 10027 (212) 678-2372
CHARLES SWAN	109 S. Union St. Suite 302 Rochester, NY 14604 (716) 325-1918
ROGER VOGT	P.O. Box No. 2 23 Plattekill Ave. New Paltz, NY 12561 (914) 255-5350
STANLEY WEAVER	1653 Central Ave. Albany, NY 12205 (518) 457-3142
FAYE WILSON	Region 3 District 2 53 Highland Ave. Middletown, NY 10940 (914) 343-7647
CYNTHIA ZAMPINO	State Office Bldg. 333 E. Washington St. Syracuse, NY 13202 (315) 428-4229

NEW YORK STATE MENTAL HYGIENE COMMISSIONERS
COUNTY MENTAL HEALTH DIRECTORS
(Alphabetical by County)

Dr. Walter Osinski, MD
Director
Albany County Mental Hygiene
South Ferry & Green Streets
Albany, NY 12202
(518) 445-7871

Mr. Robert Stone, ACSW
Commissioner
Broome County Mental Health
97 Chestnut Street
Binghamton, NY 13905
(607) 772-0151

Dr. Peter P. Midura, MD
Director
Cayuga County Mental Health
146 North Street
Auburn, NY 13201
(315) 253-0341

Mr. Henry Schurr, CSW
Director
Chemung County Mental Health
Retardation & Alcoholism
Heritage Park, High & John Streets
Elmira, NY 148901
(607) 737-2908

Mr. John Johnson, CSW
Director
Clinton County Mental Health
30 Durkee Street
Plattsburgh, NY 12091
(518) 561-7201

Mr. Leonard Jakovac
Administrative Office
Allegany County Mental Hygiene
22 West State Street
Wellsville, NY 14895
(716) 593-6300

Dr. M. Raqib Raja, MD
Director
Cattaraugus County Mental Health
201 South Union Street
Olean, NY 14760
(716) 375-4012

Mr. Anthony Bongiovanni, CSW
Commissioner
Chautauqua County Mental Health
Health & Social Services Building
Mayville, NY 14757
(716) 753-4319

Dr. K. C. Sharma, Ph.D.
Director
Chenango County Mental Hygiene
171 North Broad Street
Norwich, NY 13815
(607) 335-4632

Dr. Lawrence Berg, Ph.D., CSW
Director
Columbia County Mental Health
70 North Third Street
Hudson, NY 12534
(518) 828-9446

Dr. Charles Caparzano, Ph.D.
Director
Cortland County Mental Health
60 Central Avenue
P.O. Box 1172
Cortland NY 13045
(607) 753-5055

Dr. Kenneth M. Glatt, Ph.D.
Commissioner
Dutchess County Mental Hygiene
230 North Road
Poughkeepsie, NY 12601
(914) 485-9700

Mr. William H. Hogan, ACSW
Director
Essex County Mental Health
P.O. Box 477
Elizabethtown, NY 12932
(518) 873-6301 Ext. 67

Dr. David Thompson, Ph.D.
Director
Fulton County Mental Health Clinic
57 East Fulton Street
Gloversville, NY 12078
(518) 773-8231

Mr. Edward Gunn, CSW
Director
Greene County Mental Health
P.O. Box P
Cairo, NY 12413
(518) 622-9163

Mr. Stephen Dungan, CSW
Director
Delaware County Mental Health
Box 266
Hospital Road
Walton, NY 13856
(607) 865-6522

Dr. James J. Wardé, MD
Commissioner
Erie County Mental Health
Rath Building
95 Franklin Street, Room 1237
Buffalo, NY 14202
(716) 846-8531

Mr. Kenneth Tulloch, CSW
Director
Franklin County Mental Health
16 Elm Street
Malone, NY 12953
(518) 483-6767

Mr. Ronald Hallinen, CSW
Director
Genesee County Mental Health Services
211 East Main Street
Batavia, NY 14020
(716) 344-2550 Ext. 229

Mr. Paul L. LaRocque
Acting Director
Hamilton County Mental Health
P.O. Box 165
Indian Lake, NY 12842
(518) 648-5355

Dr. L. Laramour Bryan, MD
Director
Herkimer County Mental Health
Little Falls Hospital
10 Whited Street
Little Falls, NY 13365
(315) 823-2382

Mr. Philip McDowell, CSW
Director
Lewis County Mental Health
7785 North State Street
Lowville, NY 13367
(315) 376-7511

Dr. James J. Stack, Ph.D.
Director
Madison County Mental Health
County Office Building
Wampsville, NY 13163
(315) 366-2327

Mr. Patrick Liverio, ACSW
Director
Montgomery County Mental Health
St. Mary's Hospital
427 Guy Park Avenue
Amsterdam, NY 12010
(518) 842-1900

Dr. Sara Kellermann, MD
Commissioner
New York City Mental Health, Retardation
& Alcoholism Services
93 Worth Street, Room 407
New York, NY 10013
(212) 566-7797

Dr. Floyd L. Bajjaly, MD
Director
Jefferson County Mental Health
Mercy Hospital of Watertown
218 Stone Street
Watertown, NY 13601
(315) 782-4000

Mr. Philip Yawman, ACSW
Director
Livingston County Mental Health
Murray Hill, Building 1
Mount Morris, NY 14510
(716) 658-2834

Dr. Andreas M. Pederson, Ph.D.
Director
Monroe County Mental Health
111 Westfall Road, Room 814
Rochester, NY 14620
(716) 442-4000 Ext. 2196

Mr. Isidore Shapiro, ACSW
Commissioner
Nassau County Mental Health
240 Old Country Road
Mineola, NY 11501
(516) 535-3355

Mr. Donald A. Walck, CSW
Director
Niagara County Mental Health
Shaw Building, Mt. View Complex
5467 Upper Mount Road
Lockport, NY 14094
(716) 439-6155

Mr. Richard Lallier, CSW
Commissioner
Oneida County Mental Health
County Office Building
800 Park Avenue, 4th Floor
Utica, NY 13501
(315) 798-5903

Mr. William Swingly, CSW
Director
Ontario County Mental Health Services
County Office Building #2
County Road #46
Canandaigua, NY 14424
(716) 394-7089

Mr. Frank Endres, CSW
Director
Orleans County Mental Health
14012 Route 31 W
Albion, NY 14411
(716) 589-5676

Dr. Marvin L. Denburg, Ph.D.
Director
Otsego County Mental Health
242 Main Street
Oneonta, NY 13820
(607) 433-2343

Mr. Ara Baligian, ACSW
Commissioner
Rensselaer County Mental Health
County Office Building
1700 Seventh Avenue
Troy, NY 12180
(518) 270-5401

Dr. Donald D. Bourdreau, MD
Commissioner
Onondaga County Mental Health
421 Montgomery Street
10th Floor
Syracuse, NY 13202
(315) 425-3355

Mr. John H. Melville, CSW
Commissioner
Orange County Mental Health
Arden Hill Hospital
Harriman Drive, P.O. Drawer 471
Goshen, NY 10924
(914) 294-6185

Mr. Rupert J. Collins, CSW
Interim Director
Oswego County Mental Health
70 Bunner Street
Oswego, NY 13126
(315) 349-3260

Ms. Patricia L. Wolke, ACSW
Commissioner
Putnam County Mental Health
21 Old Route 6
Carmel, NY 10512
(914) 225-1515

Dr. Bert Pepper, MD
Director
Rockland County Mental Health
Health Complex
Pomona, NY 10970
(914) 354-0200

Mr. William Serafin, ACSW
Director
St. Lawrence County Health/Mental Health
P.O. Box 229
Potsdam, NY 13676
(315) 265-6190

Mr. Robert Albohm, CSW
Director
Schenectady County Mental Health Services
620 State Street
Schenectady, NY 12308
(518) 382-3382

Ms. Ann Birnbach, CSW
Director
Schuyler County Mental Health
111 Ninth Street
Watkins Glen, NY 14891
(607) 535-2393

Mr. Vernon Lee Woolston, CSW
Director
Steuben County Mental Health Services
117 East Steuben Street
Bath, NY 14810
(607) 776-7113

Ms. Janet Goliger, CSW
Executive Director
Sullivan County Mental Health
3 Liberty Street
Monticello, NY 12701
(914) 294-0640

Mr. Dale Angstadt, ACSW
Director
Saratoga County Mental Health
211 Church Street
Saratoga, NY 12866
(518) 584-9030

Mr. David Delehanty, CSW
Director
Schoharie County Mental Health
Schoharie Valley Professional Building
P.O. Box 160, Route 30
Schoharie, NY 12157
(518) 295-8136; 295-8146

Mr. Osvaldo Zavarella, ACSW
Director
Seneca County Mental Health
31 Thurber Drive
Waterloo, NY 13165
(315) 539-5043

Mr. John J. Ackerman, CSW
Director
Suffolk County Mental Health
225 Rabro Drive East
Hauppauge, NY 11788
(516) 979-2000

Mr. Daniel Coughlin, CSW
Director
Tioga County Mental Health
Retardation & Alcoholism
231 Main Street
Owego, NY 13827
(607) 687-4000

Mr. Anthony DeLuca, CSW
Director
Tompkins County Mental Health
1287 Trumansburg Road
Ithaca, NY 14850
(607) 274-5458

Dr. Anthony Spellman, MD
Director
Warren County Mental Health
Glens Falls Hospital
100 Park Street
Glens Falls, NY 12801
(518) 793-5148

Dr. Joseph Mabon, III, Ph.D.
Director
Wayne County Mental Health
Route 31
Newark-Lyons Road
Lyons, NY 14489
(315) 946-4873

Mr. Philip M. Murray, CSW
Director
Wyoming County Mental Health
Perry Medical Center
1 Handley Street
Perry, NY 14530
(716) 237-6141

Dr. Gerald Landsberg, DSW, MPA
Director
Ulster County Mental Health
400 Broadway
Kingston, NY 12401
(914) 331-6340

Dr. David Wasser, MD
Director
Washington County Mental Health
Mary McClellan Hospital
15 West Main Street
Cambridge, NY 12816
(518) 677-3990

Dr. Eugene Aronowitz
Director
Westchester County Mental Health
County Office Building #2
112 East Post Road
White Plains, NY 10601
(914) 682-2701

Mr. Ronald Moraski, CSW
Director
Yates County Mental Health
431 Liberty Street
Penn Yan, NY 14527
(315) 536-2139

CONTACT PERSONS FOR NEW YORK STATE DEPARTMENT OF HEALTH POISON CONTROL CENTERS

Esther Eddy, RPh
Children's Hospital
219 Bryant Street
Buffalo, NY 14222

(716) 878-7654

Howard Weinberger, MD
Upstate Medical Center
750 E. Adams Street
Syracuse, NY 13210

(315) 476-7529

Terry Wahl, MD
Ellis Hospital
1101 Nott Street
Schenectady, NY 12308

(518) 382-4039
382-4309

Richard Weisman, Pharm. D.
New York City Poison Control Ctr.
Department of Health
455 First Avenue
New York, New York 10016

(212) POISONS
(212) 340-4494

Ruth Lawrence, MD
University of Rochester
Medical Center
601 Elmwood Avenue, Box 321
Rochester, NY 14642

(716) 275-5151

Patricia March, Assistant Director
Binghamton General Hospital
Mitchell Street
Binghamton, NY 13905

(607) 723-8929

Stanley Oransky, MD
Nyack Hospital
North Midland Avenue
Nyack, NY 10960

(914) 353-1000

Howard C. Mofenson, MD
Nassau County Medical Center
2201 Hempstead Turnpike
East Meadow, NY 11554

(516) 542-2323

NEW YORK CITY SUICIDE PREVENTION HOTLINES

(212) 492-4067–	**Save a Life League**: Answered by a tape recording asking the caller for his/her name, address, and phone number and also the date of the call. It also gives an additional number to call after 2 P.M., this number is 664-0505.
(212) 532-2400–	**Help Line**: Answered by an individual, who is trained to make referrals to the appropriate agencies, 24 hrs./7 days.
(212) 464-7515–	**Dial for Help**: 24 hrs./7 days located at Creedmore Psychiatric Center; accepts calls from all over the city.